

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
**REQUEST FOR OUT-OF-HOME CARE IN THE
DDD VOLUNTARY PLACEMENT PROGRAM**

DATE OF REQUEST		NAME OF PARENT(S)	
My/our child or youth's name is _____ and he/she is _____ years old.			
I/we are the legal and custodial parents of my/our child: <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> I/we are requesting out of home placement for the child named above.			
ANY OTHER INFORMATION ABOUT YOUR CHILD'S LEGAL STATUS?			BIRTHDATE
ADDRESS WHERE YOU LIVE NOW		CITY	STATE ZIP CODE
YOUR CHILD LIVES WITH YOU AT THIS ADDRESS <input type="checkbox"/> Yes <input type="checkbox"/> No	CURRENT HOME TELEPHONE NUMBER	E-MAIL ADDRESS	
CURRENT WORK TELEPHONE NUMBER	E-MAIL ADDRESS	CURRENT CELL PHONE NUMBER	
CURRENT WORK TELEPHONE NUMBER	E-MAIL ADDRESS	CURRENT CELL PHONE NUMBER	
RCW 74.13.350 governs the Voluntary Placement Program. It requires that placement out-of-home be due solely to the child's disability.			
SIGNATURE OF PARENT	SIGNATURE OF PARENT	SIGNATURE OF DDD REPRESENTATIVE	

DSHS 10-277 (REV. 02/2006)

ATTACHMENTS: RCW 74.13.350 Brochure

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